PAYMENT FOR INPATIENT HOSPITAL SERVICES
METHODS AND STANDARDS

I. HOSPITALS UNDER PROSPECTIVE RATES

Types of rates: Inpatient hospital services, which have been authorized for payment at the acute level by a quality improvement organization (QIO-like vendor), as specified in the contract between the QIO-like vendor and Nevada Medicaid, are reimbursed by all-inclusive, prospective per diem rates by type of admission. All-inclusive per diem rates are developed for Maternity, Newborn, Neonatal, Rehabilitative/Specialty Hospital, Level I Trauma, Medical/Surgical, and Psychiatric/Substance Abuse Treatment admissions, as described in Sections II, III, and IV. Administrative day rate development is covered in Section V. Critical Access Hospitals under Medicare retrospective cost reimbursement are described in Section VII.

II. PROSPECTIVE RATE DEVELOPMENT (Prior to September 1, 2003)

The primary goals of the inpatient hospital rate methodology are: Rates should be based on actual, reasonable, and allowable hospital costs, and the rate development method should comply with federal requirements. The prospective rates are inclusive of all ancillary services required by patients.

A. Basic data sources for tier rate development.

1. The most recently filed Hospital Health Care Complex Cost Report (HCFA 2552) was the basis for identifying allowable cost. Routine cost limits were not applied.

2. Paid claims and billing information were taken from the Nevada database for Medicaid claim payment history report for services provided during the period covered by the HCFA 2552.

B. Adjustments made to determine allowable cost.

The following adjustments were made to each individual hospital's cost report:

1. An audit adjustment was applied to the total Medicaid cost for each hospital. The adjustment was determined by using an average for each hospital of the audit adjustment percentages for the three most recent years available. Adjustments for two years were used if three were not available.

2. Since the hospitals' cost report periods vary, all cost data was indexed to the same period, using the Medicare inflation factor for non-prospective payment system (non-PPS) hospitals.

III. Conversion of Existing Tier Rates to Per Diem Rates as of September 1, 2003

The current hospital inpatient tier rates for Medical/Surgical, Maternity, and Newborn inpatient categories are in effect for Medicaid payments made through August 31, 2003.

In order to convert to a MMIS system on September 1, 2003, hospital reimbursement tier rates will be converted to per diem rates. The Maternity and Newborn service categories will be retained. The service category Medical/Surgical will be converted to Level I Trauma and Medical/Surgical categories.

These new per diem rates will be effective for claims paid on or after September 1, 2003, until the rates are rebased as directed by the Department of Human Resources.

A. Maternity Rate Conversion

An all-inclusive per diem rate is paid for obstetrical hospital admissions. The rate also covers related admissions such as false labor, undelivered OB, and miscarriages.

Historical Medicaid data for the Calendar Year (CY) ended December 31, 2002, has been extracted showing Medicaid Maternity admissions and Maternity patient days by tier. Projected Maternity payments for each tier are calculated as CY2002 Maternity admissions per tier times the current tier rate. Total projected Maternity payments are the sum of all projected tier payments.

The conversion per diem rate for Maternity has been determined by the following formula:

$$\frac{\text{Total Projected Maternity Payments}}{\text{CY2002 Historical Maternity Patient Days}} = \text{Maternity Per Diem Rate}$$

B. Newborn Rate Calculation

An all-inclusive per diem rate will be developed for newborns admitted through routine delivery at a hospital.

Historical Medicaid data for the Calendar Year (CY) ended December 31, 2002, has been extracted showing Medicaid Newborn admissions and Newborn patient days by tier. Projected Newborn payments for each tier are calculated as CY2002 Newborn admissions per tier times the current tier rate. Total projected Newborn payments are the sum of all projected tier payments.

The conversion per diem rate for Newborn has been determined by the following formula:

$$\frac{\text{Total Projected Newborn Payments}}{\text{CY2002 Historical Newborn Patient Days}} = \text{Newborn Per Diem Rate}$$

C. Neonatal Intensive Care Rate Calculation

A separate rate is used for patients admitted to Level III Neonatal Intensive Care Units.

The current rate was developed from historical costs pursuant to Section II, Prospective Rate Development. The calculated cost per day of each neonatal unit was arrayed from highest to lowest. The prospective per diem rate was then calculated at the 55th percentile and indexed.

The current rate will continue until rebased as directed by the Department of Human Resources.

D. Rehabilitative and Specialty Hospital Rate Calculation

A few Nevada hospitals are licensed to provide acute care in single diagnostic category. Rehabilitative and specialty hospital patients generally have hospital stays of ninety or more days. The length of stay does not significantly influence the cost per day.

To the extent these hospitals participate in Medicaid, they are reimbursed under Medicare's retrospective cost reimbursement, as follows:

1). Inpatient hospital services which have been certified for payment at the acute level by a QIO-like vendor, as specified in the contract between the QIO-like vendor and Nevada Medicaid, upon final settlement are reimbursed allowable costs under hospital-specific retrospective Medicare principles of reimbursement in accordance with 42 CFR Part 413.30 and 413.40, Subpart C, and further described in CMS Publications 15-I and 15-II for all payments made prior to September 1, 2003.

2) On an interim basis, each hospital is a paid a facility specific rate per day.

For payments made on or after September 1, 2003, these facility specific rates will be used as prospective rates for each facility until rates are rebased as directed by the Department of Human Resources. There will be no cost settlement to these facilities for any payments made on or after September 1, 2003.

E. Medical/Surgical Rate Development

The current tier rate will be paid for Medical/Surgical payments made on or prior to August 31, 2003. Beginning September 1, 2003, an all-inclusive per diem rate will be paid for general hospital admission, not meeting the criteria of patients described in Parts B. - D. and F. of this Section or Section IV.

Historical Medicaid data for the Calendar Year (CY) ended December 31, 2002, has been extracted showing Medicaid Medical/Surgical admissions and Medical/Surgical patient days by tier. Projected Medical/Surgical payments for each tier are calculated as CY2002 Medical/Surgical admissions per tier times the current tier rate. Total projected Medical/Surgical payments are the sum of all projected tier payments.

The conversion per diem rate for the Medical/Surgical category has been determined by the following formula:

$$\frac{\text{Total Projected Medical/Surgical Payments}}{\text{CY2002 Historical Medical/Surgical Patient Days}} = \text{Medical/Surgical Per Diem Rate}$$

F. Level I Trauma Centers

Nevada Medicaid will pay an enhanced rate for full trauma team cases at Level I Trauma Centers. For payments made on or before August 31, 2003, the enhanced trauma rate is 1.63 times the Medical/Surgical tier rate. For services paid September 1, 2003, and after the enhanced trauma rate is 1.63 times the Medical/Surgical per diem rate described in Part E. of this Section.

IV. PSYCHIATRIC/SUBSTANCE ABUSE TREATMENT RATE DEVELOPMENT

Psychiatric/substance abuse treatment admissions can vary from short stays to several weeks. The length of stay does not significantly impact the cost per day. Therefore, a per diem rate is a more appropriate method to pay acute care hospitals providing this type of service.

Psychiatric/substance abuse treatment costs for each hospital are divided by the number of psychiatric/substance abuse treatment days to determine a cost per day. The Medicaid related costs of freestanding psychiatric hospitals are determined using the steps in Section II, Parts A and B, then dividing their Medicaid costs by their total Medicaid days to determine the cost per day. The calculated cost per day of each general acute care hospital and freestanding psychiatric hospital is arrayed from highest to lowest. The prospective per diem rate is then calculated at the 55th percentile and indexed in accordance with Section II, Part E of this plan.

These rates do not apply to facilities accredited as Residential Treatment Centers by the Joint Commission on Accreditation of Health Organizations (JCAHO).

V. ADMINISTRATIVE DAY RATE DEVELOPMENT

For those patients who remain in an acute care hospital awaiting admittance to a long-term care facility, an administrative day rate is used. Services so reimbursed are call "administrative days."

The administrative rate is calculated each year. It is based on the most recent statewide weighted average payment rate for skilled and intermediate levels of care plus a 100% factor. Under certain circumstances, up to an additional 300% is added for a patient with exceptional or abnormal needs; for example, patients in need of isolation, ventilation dependency, or total parental nutrition. The administrative rate, plus the maximum 300% factor, is lower than the hospital rate as described in Part II of the State Plan.

VI. RESIDENTIAL TREATMENT CENTERS

Nevada Medicaid will only pay for stays in facilities accredited by the Joint Commission on Accreditation Health Organizations (JCAHO) as Residential Treatment Centers (RTCs). All stays must be pre-approved by the QIO-like vendor. These services will be reimbursed at the lowest rate acceptable to both parties. In establishing the lowest rate acceptable to both parties, Nevada Medicaid reviews cost information filed by the RTC, amounts paid by other insurers, and national literature on costs for RTCs. Each facility will have a negotiated rate established for each general level of service. If a placement is being proposed which is different from the general level of care offered by the facility, a rate will be negotiated after considering the average cost per day of the facility and the additional will be reviewed based upon cost information received on or prior July 1 of the year of review. The rate cannot exceed the reasonable and customary charges of the facility for similar services.

VII. HOSPITALS UNDER MEDICAID RETROSPECTIVE COST REIMBURSEMENT (CRITICAL ACCESS HOSPITALS)

A few Nevada hospitals have been designated by Medicare as Critical Access Hospitals.

To the extent these hospitals participate in Medicaid, they are reimbursed under Medicare's retrospective cost reimbursement, as follows:

A. Inpatient hospital services which have been certified for payment at the acute level by the QIO-like vendor, as specified in the contract between the QIO-like vendor and Nevada Medicaid, upon final settlement are reimbursed allowable costs under hospital-specific retrospective Medicare principles of reimbursement in accordance with 42 CFR Part 413.30 and 413.40, Subpart C, and further described in CMS Publications 15-I and 15-II.

B. On an interim basis, each hospital is paid for certified acute care at the lower of 1) billed charges, or 2) the rate paid to general acute care hospitals for the same services.

Facilities accredited as Residential Treatment Centers by the Joint Commission on Accreditation of Health Organization (JCAHO) are not considered specialty or general acute hospitals. Residential Treatment Centers are paid in accordance with paragraph VI above.

VIII. HOSPITALS SERVING LOW-INCOME PATIENTS
DISPROPORTIONATE SHARE HOSPITALS

A. Subject to the provisions of subparagraph 6, a hospital will qualify as disproportionate if it meets any of the conditions under subparagraphs 1 through 5.

1. A hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State.

2. The hospitals low income utilization is at least 25%. Low income utilization is the sum (expressed as a percentage) of the fractions, calculated as follows:

a) Total Medicaid patient revenues paid to the hospital, plus the amount of the cash subsidies for patient service received directly from State and local governments in the cost reporting period, divided by the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the same cost reporting period; and,

b) The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, less the portion of any cash subsidies received directly from the state or local government, divided by the total amount of hospital charges for inpatient services in the hospital in the same period. The total inpatient hospital charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medicaid assistance under an approved Medicaid State plan), that is, reductions in charges given to other third party payors, such as HMOs, Medicare, or Blue Cross Blue Shield.

3. For public hospitals (i.e., hospitals owned or operated by a hospital district, county or other unit of local government), the hospital's Medicaid inpatient utilization rate is at least one percent.

4. For counties which do not have a public hospital, the hospital in the county which provided the greatest number of Medicaid inpatient days in the previous year.

5. A private hospital located in a county with a public hospital that has a Medicaid utilization rate greater than the average for all the hospitals receiving Medicaid payment in the State.

6. A hospital must:

a.) have a Medicaid inpatient utilization rate not less than one percent,

b.) have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget) the term "obstetrician" include any physician with staff privileges at the hospital to perform non-emergency obstetric procedure. This does not apply to a hospital in which:

i.) The inpatients are predominantly individuals under 18 years of age; or

ii) Does not offer non-emergency obstetric services as of December 21, 1987.

c.) not be an institution for mental disease or other mental health facility subject to the limitation on DSH expenditures under Section 4721 of the Balanced Budget Act of 1997.

7. Medicaid utilization rate means the total number of days of treatment of Medicaid patients, including patients who receive their Medicaid benefits through a health maintenance organization, divided by the total number of days of treatment of all patients during a fiscal year.

B. Distribution Pools: Hospitals qualified under paragraph 'A' above will be grouped into distribution pools on the following basis:

1. Assuming total available DSH in a given fiscal year of $76,000,000, distribution pools are established as follows:

a) All public hospitals qualifying under paragraph A above and in counties whose population is 400,000 or more, the total annual disproportionate share payments are $66,650,000 plus 90% of the total amount distributed by the DHCFP in that fiscal year that exceeds $76,0000.

b) All private hospitals qualifying under paragraph A above and in counties whose population is 400,000 or more, the total annual disproportionate share payments are $1,200,000 plus 2.5% of the total amount distributed by the DHCFP in that fiscal year that exceeds $76,0000.

c) All private hospitals qualifying under paragraph A above and in counties whose population is 100,000 or more but less than 400,000, the total annual disproportionate share payments are $4,800,000 plus 2.5% of the total amount distributed by the DHCFP in that fiscal year that exceeds $76,0000.

d) All public hospitals qualifying under paragraph A above and in counties whose population is less than 100,000, the total annual disproportionate share payments are $900,000 plus 2.5% of the total amount distributed by the DHCFP in that fiscal year that exceeds $76,0000.

e) All private hospitals qualifying under paragraph A above and in counties whose population is less than 100,000, the total annual disproportionate share payments are $2,450,000 plus 2.5% of the total amount distributed by the DHCFP in that fiscal year that exceeds $76,0000.

2. In no circumstances may the total amount of distributions to hospitals within distribution pools noted in 1. above exceed the total uncompensated costs for those facilities.

3. Uncompensated costs are determined by the sum of the cost for providing services to inpatient and outpatient Medicaid and uninsured patients less Medicaid payments (excluding disproportionate share payments) and any patient paid or third party paid amounts. (Third party amounts exclude any payments made by a State or locality to a hospital for services provided to indigent patients.) An "uninsured patient" is defined as an individual for whom services received by the patient are not covered by insurance, whether this coverage is medical or liability based coverage. Patient paid and third party paid amounts are based on the historical collection experience of the hospital for uninsured accounts or actual collections in the fiscal year, whichever is greater. A system must be maintained by the hospitals to match revenues on Medicaid and uninsured patient accounts to the actual billed charges of the accounts in the same fiscal year. Costs for Medicaid and uninsured patients will be based upon the methodology used for a HCFA 2552 report. Revenue will be deducted from cost. The total costs on the report will be subject to an independent audit, which must be submitted within six months of the hospital's fiscal year end.

C. Hospital Base Payments

1. Based on a study of hospital uncompensated costs completed in SFY2003, certain hospitals qualifying for DSH under paragraph A and subject to the limitations in paragraph B above, will receive the following annual DSH payments:

a)	University Medical Center of Southern Nevada	$66,531,729
b)	Washoe Medical Center	$ 4,800,000
c)	Carson-Tahoe Hospital	$ 1,000,000
d)	Northeastern Nevada Regional Hospital	$ 500,000
e)	Churchill Community Hospital	$ 500,000
f)	Humboldt General Hospital	$ 215,109
g)	William Bee Ririe Hospital	$ 204,001
h)	Mt. Grant General Hospital	$ 195,838
i)	South Lyon Medical Center	$ 174,417
j)	Nye Regional Medical Center	$ 115,000

2. The successor interest in the hospitals in subparagraph 1 above will receive these base payments so long as the facility continues to meet DSH criteria defined in this plan.

3. In no circumstances may the total amount of distributions to hospitals within distribution pools noted in 1. above exceed the total uncompensated costs for those facilities.

D. Distributions within Pools - Total available DSH is distributed to hospitals qualifying under paragraph A above within the pools described in paragraph B above on the following basis:

1. To the extend they do not exceed the pools established in paragraph B above, all base payments established in paragraph C above are made.

2. Any amount set forth in paragraph B above after all distributions under paragraph C will be distributed to the hospital within each pool with the highest uncompensated care percentage or the amount necessary to reduce the uncompensated care percentage of that hospital in the same pool with the second highest uncompensated care percentage.

3. Any amount remaining within a pool after the distributions described in subparagraphs a) and b) will be distributed to the two hospitals within the pool with the highest uncompensated care percentage or the amount necessary to reduce their uncompensated care percentages to that of the hospital in the same pool with the third highest uncompensated care percentage. This process continues until all funds within a distribution pool are distributed.

4. As used in this section, uncompensated care percentage is defined as the total uncompensated costs of a hospital divided by the total revenue for that hospital.

E. Proportional Reductions - In the event the total available DSH is in a given state fiscal year is less than the amount described in paragraph B above, the following reductions will be made:

1. The amount of the distribution pools described in paragraph B above will be reduced by the same percentage as the percentage change from $76,000,000 to total available DSH.

2. To the extend the total base payments described in paragraph C above exceed their respective pools described in subparagraph 1 above, the base payments will be reduced by the same percentage as the percentage change from $76,000,000 to the total available DSH or until the total base payments within a pool are equal to that pool.

IX. MEDICARE CROSS OVER CLAIMS

Payment of crossover claims will be as follows:

A. The lower of the Medicare deductible amount or the difference between the Medicare payment and Medicaid prospective payment for that service.

X. HOSPITALS OUT OF STATE

Elective out-of-state admissions require prior authorization by Nevada Medicaid's Peer Review Organization, which must verify medical services required by Medicaid-eligible or pending-eligible clients are not available in Nevada. The out-of-state payment rate for inpatient care is based on one of the following criteria, whether emergency or elective in nature.

A. For California hospitals, the following rates will be paid:

1. If the hospital has no signed contract with the State of California to provide Medi-Cal services, the California interim reimbursement Medi-Cal rate.

2. If the hospital has a signed contract with the State of California to provide Medi-Cal services, the Medi-Cal contract rate is paid. If the contract rate is not made available to Nevada Medicaid, the California interim Medi-Cal rate is paid.

B. For Utah hospitals the payment rate is 70 percent of billed charges.

C. For all other states' hospitals, the payment rate will be either the Nevada Medicaid prospective rate or the Medicaid rate for the state in which the hospital is located, but not more than billed charges. To receive the Medicaid rate for the state in which the hospital is located, the hospital must attach documentation to the UB-92 billing claim, produced and generated by that state's Medicaid program, verifying the state's payment rate to that hospital.

D. All other states' freestanding psychiatric/substance abuse hospitals are reimbursed 70 percent of billed charges.

E. For Medicare crossover claims, the payment will be the lower of the Medicare deductible amount or the difference between the Medicare payment and the Nevada Medicaid prospective payment for that service.

F. Nevada Medicaid may negotiate a rate only if an out-of-state hospital refuses to accept the rate methodology as outlined in sections A through E, and meets the following criteria:

1. The Nevada Medicaid-eligible or pending-eligible client requires medical services which, if not provided within 30 days, could result in very severe pain, loss of life or limb, loss of eyesight or hearing, injury to self, or bodily harm to others, and

2. The Medicaid client's or pending-eligible client's specific surgery or medical procedure is provided only in a limited number of out-of-state hospitals, and, in Nevada Medicaid's judgment, the hospital most cost-effective will be the hospital Medicaid authorizes to provide the service.

XI. RATE ADJUSTMENTS

Payment is made for services provided in inpatient hospital facilities in accordance with Section 1902(a)(13) of the Social Security Act as amended by Section 4711 of the Balanced Act of 1997. Prospective payment rates are based using the most current hospital costs reports (HCFA 2552) and cost reimbursement series (CRS) reports following the steps described in Section II - V above. Rates in effect on June 30, 1999 will be continued without adjustment except as may be directed by the Department of Human Resources.

XII. MONITORING FUTURE RATES

Nevada Medicaid monitors cost and utilization experience of all hospitals by evaluation of the cost reports filed each year. Payments are examined closely. Should modification of any elements or procedures such as creation or deletion of a rate or group appear necessary, this State Plan Attachment will be amended.

XIII. ADVANCES

Upon request, each hospital may receive each month an advance payment that represents expected monthly Medicaid reimbursement to that facility. Each advance is offset by claims processed during the month. Month-end +/- discrepancies automatically adjust the advance issued the following month.

XIV. DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS

This section of the state plan contains the provisions for making additional Medicaid payments to recognize the additional direct costs incurred by in-state hospitals with approved graduate medical education programs. These provisions become effective at the start of each qualifying hospital's fiscal period beginning on or after July 1, 2003.

A. Qualifying Hospitals:

In-state hospitals that participate in the Medicaid program are eligible for additional reimbursement related to the provision of Graduate Medical Education (GME) activities. To qualify for these additional Medicaid payments, the hospital must also be eligible to receive GME payments from the Medicare program.

B. Methodology for Determining GME Payments:

Each in-state hospital that qualifies for direct GME payments will have their hospital specific payments amount determined as follows:

1. Maximum Direct GME Disbursement Amount: Medicaid will reimburse a maximum amount of $820,429 for direct GME without adjustment.
2. Total Full Time Equivalent (FTE) Calculation: Medicaid will calculate a total number of actual Medicaid FTEs using data from each qualifying hospital.
    a. Each qualifying hospital will provide documentation of actual paid FTEs for the previous fiscal year to Medicaid by April 1st of each year. This will be the maximum number of FTEs that may qualify for direct GME reimbursement.
    b. The Medicaid portion of each qualifying hospital's maximum number of FTEs will be determined by dividing the hospital's Medicaid inpatient days by total inpatient days. The data will be from the most current available audited Medicare cost report as of April 1st of each year. This fraction will be multiplied by the hospital's maximum number of FTEs for the actual Medicaid FTEs for the hospital.
    c. Medicaid will sum each of the qualifying hospitals' number of actual Medicaid FTEs for a total number of actual Medicaid FTEs. This will be the number of FTEs used in direct GME disbursement calculation.

3. Medicaid Direct GME Reimbursement Amount per FTE: Medicaid will divide the maximum direct GME disbursement amount by the total number of actual Medicaid FTEs to calculate the reimbursement amount for FTE.
4. Medicaid Direct GME Reimbursement per hospital: Medicaid will multiply the actual Medicaid FTEs of each qualifying hospital by the reimbursement amount per FTE to calculate a total direct GME reimbursement by hospital.

C. Payments of Direct GME:

Beginning July 1, 2003, Medicaid will calculate the total direct GME reimbursement for each qualifying hospital using the methodology in **B.** above. At the end of each calendar quarter, each hospital will receive a payment amount equal to twenty-five percent (25%) of the hospital's total direct GME reimbursement.